Leadership Council of Aging Organizations

ISSUE BRIEF
JANUARY 2014

Altering Extra Help Copayments: A Flawed Savings Approach

Background:

The Low-Income Subsidy program, commonly known as Extra Help, offers assistance to low-income Medicare beneficiaries for prescription drug costs.[1] In 2011, 11.8 million people with Medicare (23%) were enrolled in Extra Help.[2] Estimates suggest another 2 million beneficiaries are eligible for the benefit but not enrolled.[3]

According to the Centers for Medicare and Medicaid Services (CMS), Extra Help saves low-income beneficiaries an estimated $4,000 per year.[4] By definition, the Extra Help program serves some of the most vulnerable people with Medicare, many of whom have significant health needs. The average number of prescriptions filled per month by a person with Extra Help is 5.1 compared with 3.8 for those without the subsidy.

In 2012, the Medicare Payment Advisory Commission (MedPAC) recommended altering generic and brand name copayments in the Extra Help program, with the stated goal of, "…encouraging generic and therapeutic substitutions in classes where such substitutions are clinically appropriate." MedPAC suggested eliminating the copayment for generic medications and increasing the copayment for brand name medications, with varying copayments for preferred tiers and non-preferred tiers. Where no generic substitution is available for a medication, the copayment structure would remain as is under current law.[5]

People with Extra Help:

Full Extra Help is available to people also enrolled in Medicaid and a Medicare Savings Program, as well as those with incomes at or below 135% the Federal Poverty Level (about $15,500 for an individual) and limited assets (no more than $8,660 for an individual). **Full Extra Help benefits include:**

- $0 plan premium
- $0 plan deductible
- Reduced copayments

Partial assistance is available to Medicare beneficiaries with annual incomes between 135% FPL to 150% of FPL (about $17,235 for an individual) and with limited assets (no more than $13,440 for an individual). **Partial Extra Help benefits include:**

- Reduced premium based on income
- $66 plan deductible
- Reduced coinsurance or copayments

It is important to note that the MedPAC proposal would apply higher copayments to brand name drugs for which there are "therapeutic substitution" (one non-identical drug in a therapeutic class for another) as well as to those with generic substitutions (identical chemical composition of drugs) on the market. While the MedPAC recommendations allow the Secretary to exclude some therapeutic classes from the proposed copayment adjustments, specifically in classes where therapeutic substitution is not well tolerated, these exclusions may not be broad enough to protect affordable access to needed brand-name drugs.

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[1] See text box "People with Extra Help" for additional details on full and partial Extra Help benefits. Benefits vary based on beneficiary income and the receipt of other health benefits, like Medicaid and the Medicare Savings Programs. Extra Help copayments for those receiving full benefits range from $1.15 to $2.65 for generic medications and from $3.50 to $6.60 for brand name drugs. See: Medicare Interactive, "Extra Help Program, Income and Asset Limits 2013," (2013). Full benefit dual eligibles in institutions and those receiving an institutional level of care in the community have no copayments under current law.

[2] MedPAC, "A Data Book: Health Care Spending and the Medicare Program," (June 2013)

[3] Kaiser Family Foundation, "Medicare Prescription Drug Benefit Fact Sheet," (November 2013)

[4] Social Security Administration (SSA), "Extra Help with Medicare Prescription Drug Plan Costs," (2013)

[5] MedPAC, "Report to the Congress: Medicare Payment Policy," (March 2012)

MedPAC acknowledges that limited cost sharing alone is not the sole factor contributing to disproportionate use of brand name drugs by Extra Help enrollees. Among those listed are differences in health status, prescriber behavior and pharmacy incentives and variation across states in generic substitution laws.[6] Despite this multitude of factors, the proposed recommendations *only* address beneficiary cost sharing.

Position:

The Leadership Council of Aging Organizations (LCAO) does not support increasing the Extra Help copayment for brand name medications. Depending on the proposed increase in copayments, the cost of medications could more than triple for some Extra Help beneficiaries, making needed prescriptions unaffordable.

Multiple studies suggest increased cost sharing deters access not just for unneeded health care services and medicines, but also to those that are necessary; these effects are most acute for beneficiaries with the lowest incomes. In the long run, reductions in the use of medically necessary care can, in fact, increase health care spending through the increased likelihood of emergency room visits, ambulance rides and hospital stays.[7]

Rationale:

People with Extra Help are among the most vulnerable Medicare beneficiaries. Extra Help beneficiaries tend to be women, individuals with limited proficiency in English and people of color. A disproportionate share of people with Extra Help (43%) is people with disabilities under the age of 65.[8] By definition, people with Extra Help have incomes at, below or near the federal poverty level and limited savings.

These beneficiaries also tend to be sicker than those without Extra Help and take multiple medications. People with Extra Help are not positioned to shoulder any additional health care costs. Although seemingly small, even a several dollar increased copayment for brand name medications will be burdensome for those beneficiaries who must take one, or several, brand name drugs.

Increased cost sharing is shown to deter access to needed medical care. Decades of empirical research demonstrate that increased cost sharing leads people to forgo medically necessary services, such as not complying with prescribed drug use due to cost or putting off preventive care until expensive emergency services are needed. These adverse consequences are especially pronounced for people with low, fixed incomes. As a result, higher cost sharing backfires, since sicker patients will require more costly care down the road.[9]

Physicians and other health care providers write prescriptions—not patients. In addition to heightened disease burden among people with Extra Help, MedPAC acknowledges that disproportionate use of brand name drugs by Extra Help enrollees is also driven by prescriber behavior. Literature on cost sharing and patient behavior confirms that it is health care providers who drive utilization of health care, not their patients. A better and more efficient approach is to contact prescribers directly about medically-appropriate substitutions.

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[6] MedPAC, "Report to the Congress: Medicare Payment Policy," (March 2012)
[7] Swartz, K. "Cost-Sharing: Effects on Spending and Outcomes" Robert Wood Johnson Foundation Research Synthesis Report No. 20 (December 2010)
[8] MedPAC, "A Data Book: Health Care Spending and the Medicare Program," (June 2013)
[9] "Medicare Supplement Insurance First Dollar Coverage and Cost Shares Discussion Paper" National Association of Insurance Commissioners, Senior Issues Task Force, Medigap PPACA Subgroup (October 2011); Amal N. Trivedi, et. al. "Increased Ambulatory Care Copayments and Hospitalizations Among the Elderly" *New England Journal of Medicine* (January 2010); Swartz, K. "Cost-Sharing: Effects on Spending and Outcomes" Robert Wood Johnson Foundation Research Synthesis Report No. 20 (December 2010) ; Ku, L. and V. Wachino, "The Effect of Increased Cost-Sharing in Medicaid," (Center for Budget and Policy Priorities: July 2005)

The Medicare Part D appeals system needs repair. Many people with Medicare are unaware of their right to appeal generic substitution or are deterred from seeking an appeal by an overly burdensome process. Beneficiary advocates have long called for improved beneficiary-facing information at the pharmacy counter as well as a more automatic appeals system, ideally initiated at the point of sale.[10] People with Extra Help forced to pay a higher copayment for a brand name medication or a drug that is similar, but not identical, to what they require may be deterred from acquiring a needed medication because the appeals system proves overly burdensome and complicated. In the absence of a streamlined, accessible appeals system, some beneficiaries for whom therapeutic or generic substitution is not appropriate may be forced to pay a higher copayment for a brand name drug and are at risk of going without these medications altogether.

Care coordination initiatives for dually eligible beneficiaries permit the elimination of drug copayments. Ongoing initiatives to better coordinate care for the most vulnerable people with Medicare, those dually eligible for both Medicaid and Medicare, adopt a broader stance to facilitate medication access—the elimination of cost sharing for prescription drugs altogether. Recent contracts agreed to by CMS and multiple states participating in an initiative to coordinate care for dually eligible beneficiaries, including California, Ohio, Illinois, South Carolina, Virginia and Washington, allow for the following: "Participating plans may elect to reduce this cost sharing for all enrollees as a way of testing whether reducing enrollee cost sharing for pharmacy products improves health outcomes and reduces overall health care expenditures through improved medication adherence under the demonstration."[11] It is anticipated that plans in several states will use this authority to eliminate cost sharing for all covered drugs to encourage adherence. These demonstrations should be allowed to test their impact on beneficiaries before wider changes are implemented.

Low-income populations require education on generic medications. Several studies confirm that low-income populations, including many people of color, remain skeptical of generic medications, fearing that generic alternatives are lower quality and more likely to cause side effects compared to brand name drugs. One 2011 study found that low-income participants in a rural Alabama community outreach program chose to go without prescribed brand name medications despite the availability of generic options.[12] These findings demonstrate that cost sharing alone is not an adequate tool to encourage generic medication use. Educational intiatives are needed to explain the merits of generic prescription drugs. Such initiatives should be undertaken before imposing additional cost burdens on these vulnerable populations.

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[10] Medicare Rights Center, "Facts & Faces: Refused at the Pharmacy Counter, How to Improve Medicare Part D Appeals," (Winter 2013); Sanders, S. "Letter to MedPAC on Medicare Part D Appeals," (September 2013)

[11] Seven of eight CMS-State Memorandum of Understanding (MOU) approved to date included the language noted here. Although different language is included in the MOU, the New York State MOU also allows for reduced Part D cost sharing by participating plans, making no distinction between brand name or generic medications. See Medicare-Medicaid Coordination Office, "Approved Demonstrations-Signed MOUs" (December 2013)

[12] Thomas, K., "Why the Bad Rap on Generic Drugs?" *The New York Times* (October 5, 2013)